UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

HELEN RUNGE,
Plaintiff,
v.

WALTER J. KELLEY; KERRY L. BLOOMINGDALE, M.D.; and SUNBRIDGE NURSING AND REHABILITATION CENTER,
Defendants.

Civil Action No. 05-10849-RGS

OPPOSITION of DEFENDANT MEDIPLEX OF MASSACHUSETTS, INC. d/b/a SUNBRIDGE CARE AND REHABILITATION FOR RANDOLPH to PLAINTIFF'S MOTION TO COMPEL DISCOVERY RESPONSES

The Plaintiff seeks production of records from a facility that is no longer owned by the Defendant Mediplex of Massachusetts, Inc. d/b/a SunBridge Care and Rehabilitation for Randolph (SunBridge). On July 20, 2006, as part of its automatic disclosures, SunBridge provided the Plaintiff with 485 pages of documents consisting of Helen Runge's medical file for the three months she resided at the then SunBridge facility. Following extensive contacts between counsel for SunBridge and the new operators of the subject facility, another 106 pages of facility records were obtained on March 6, 2007 and produced to the Plaintiff on March 8, 2007. These records consist of financial records related to Helen Runge. These records produced by SunBridge represent considerable effort to comply with discovery and represent all responsive documents SunBridge has been able to obtain from the new facility operator, with the exception of those documents listed in SunBridge's privilege log attached to Plaintiff's motion to Compel as Exhibit D (see Docket Entry # 88).

The Plaintiff now has all facility records related to Ms. Runge's medical care at the facility and all records of financial transactions related to her brief stay.

With regard to Resident Assessment Protocols (RAPs), one item specifically listed in Plaintiff's motion as not having been produced, the RAPs were produced within the original set of documents produced by SunBridge. See **Exhibit A-1 and A-2 –** Resident Assessment Protocol Reports (00404-428), **Exhibit B –** Minimum Data Set (00396-403) and **Exhibit C –** Resident Assessment and Care Screening (00392-395).

In light of the Plaintiff's mere three month stay at the facility in question, the 609 pages of records obtained by SunBridge from the current operators of the facility represents significant compliance with Plaintiff's document requests. Further, given that the Plaintiff has not produced a single page of documents in response to SunBridge's discovery requests, the complaint that SunBridge has failed to adequately participate in the discovery process rings hollow.

This Honorable Court should deny *Plaintiff's Motion to Compel Discovery Responses from Defendant SunBridge Nursing and Rehabilitation Center*.

Respectfully submitted,

Mediplex of Massachusetts, Inc. d/b/a SunBridge Care and Rehabilitation for Randolph

by its attorneys,

/s/ Michael Williams

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CERTIFICATE OF SERVICE

I hereby certify that this Document filed through the ECF system will be sent electronically to the registered participants as identified on the Notice of Electronic Filing (NEF) and paper copies will be sent to those indicated as non registered participants on March 13, 2007.

/s/ Michael Williams

SUNBRIDGE C & R RANDOLPH

01/30/03 11:42 RESIDENT ASSESSMENT PROTOCOL REPORT

Resident Name: RUNGE, HELEN
Resident Number: 3-0012-0 Room: 365-A
Assessment Date: 01/29/2003 Ver: Rsn: 01

DELIRIUM RAP Code: 001

** Triggers **

Assess/ ICD-9	Description	Prblm Code	MDS Cde
N6 007	Cognitive status, skills,abilities - deteriorated	N/A	B6=2

COG. LOSS/DEMENTIA RAP Code: 002

** Triggers **

Assess/ ICD-9	Description	Prblm Code	MDS Cde
G6 001	Memory deficit-Short term(no recall after 5 min.)	PS6	B2a=1
GM 003	Decisions-Mod Independentdifficulty-new situations	N/A	B4=1
GF 006	Usually understands verbal information	N/A	C6=1

VISUAL FUNCTION RAP Code: 003

** Triggers **

Assess/ ICD-9	Description	Prblm Code	MDS Cde
K8 004	Vision-impaired-sees large, not regular print	N/A	D1=1

COMMUNICATION RAP Code: 004

** Triggers **

Assess/ ICD-9	Description	Prblm Code	MDS Cde
K2 [illegible]1	Hearing - min. difficultywhen not in quiet setting	N/A	C1=1
GF [illegible]07	Usually understands verbal information	N/A	C6=1

ADL FUNCTIONAL REHAB RAP Code: 005

** Triggers **

Assess/ ICD-9	Description	Prblm Code	MDS Cde
Group #: 01 REHAB/REST.			
33 001	Dressing-Limited Assist	AD3	G1gA=2
Q9 001	Staff believes res. capable of inc. ind. ADLs	N/A	G8b

PSYCHOSOC WELL BEING RAP Code: 007

** Triggers **

Assess/ ICD-9	Description	Prblm Code	MDS Cde
PP 009	Establishes own goals	N/A	F1d

Resident Name: RUNGE, HELEN
Resident Number: 3-0012-0 Room: 365-A
Assessment Date: 01/29/2003 Ver: Rsn: 01

MOOD STATE RAP Code: 008

** Triggers **

Assess/ ICD-9	Description	Prblm Code	MDS Cde
Hn 017	Repetitive anxious complaints/concerns	MB4	E1i=1
H4 027	Repetitive physical mvmtshandwringing, pacing, etc	MB4	E1n=1
Hs 033	Mood persistence: indictrpresent, easily altered	N/A	E2=1

BEHAVIORAL SYMPTOMS RAP Code: 009

** Triggers **

Assess/ ICD-9	Description	Prblm Code	MDS Cde
V2 001	Wandering: 1-3 days	MBE	E4aA=1

FALLS RAP Code: 011

** Triggers **

Assess/ ICD-9	Description	Prblm Code	MDS Cde
V2 003	Wandering: 1-3 days	MBE	E4aA=1

PSYCHOTROPIC DRUG RAP Code: 017

** Triggers **

Assess/ ICD-9	Description	Prblm Code	MDS Cde
MQ 001	Antipsychotics	MBR	O4a
Group #: 01 HYPOTENSION/GAIT DST			
H4 001	Repetitive physical mvmtshandwringing, pacing, etc	MB4	E1n=1
MQ 004	Antipsychotics	MBR	O4a
Group #: 01 COG./BEH. IMPAIRMENT			
IB 004	Depression	PYB	I1ee
N6 004	Cognitive status, skills,abilities - deteriorated	N/A	B6=2

Resident Name: RUNGE, HELEN
Resident Number: 3-0012-0 Room: 365-A
Assessment Date: 01/29/2003 Ver: Rsn: 01

DELIRIUM RAP Code: 001

** RAP Key Summary **

Assess/ ICD-9	Description	MDS Cde
1:	*Consider if delirium is related to medical diagnoses or other physiological conditions?	
	9D Anemia	I1oo
2:	Additional diagnoses to consider - myocardial infarction, surgical abdomen, head trauma, hypothermia, hypoglycemia.	
3:	*Consider if delirium is due to medications? (new meds, number of meds, combination/interactions of meds)	
	MV # of different meds used 05	O1
	NK Received new medications- in last 7 days	O2
	MQ Antipsychotics 7 days	O4a
4:	Consider additional classifications of meds - cardiac meds, GI meds, analgesics, anti-inflammatory meds.	
5	Consider over-the-counter drugs such as; cold remedies, sedatives, stay-awakes, antinauseants, alcohol.	
6:	Consider if delirium is due to psychological factors; recent loss, isolation, restraints, sad/anxious mood.	
	Hn Repetitive anxious complaints/concerns	E1i
	H4 Repetitive physical mvmts handwringing, pacing, etc	E1n
	Hs Mood persistence: indictr present, easily altered	E2=1
	IB Depression	I1ee
7:	Condisder if delirium is due to a recent relocation, i.e., new room, unit, facility.	
8:	Consider if delirium is due to sensory impairment, i.e., hearing deficit, visual deficit.	
	K2 Hearing - min. difficulty when not in quiet setting	C1=1
	K8 Vision-impaired-sees large, not regular print	D1=1
9:	CLARIFYING INFORMATION TO CONSIDER:	
10:	*Does resident have recent sleep disturbance?	
11:	*Does resident have Alzheimer's or other dementia?	

Resident Name: RUNGE, HELEN
Resident Number: 3-0012-0 Room: 365-A
Assessment Date: 01/29/2003 Ver: Rsn: 01

DELIRIUM RAP Code: 001

** RAP Key Summary **

Assess/ ICD-9	Description	MDS Cde
FC	Dementia not Alzheimer's	I1u

12: Has the time of symptom onset of the resident's cognitive & behavioral function been within the last few hours to days?

13: Is the resident's environment conducive to reducing symptoms (e.g., quiet, well-lit, calm, familiar objects present)?

14: *Is the resident's daily routine broken down into smaller tasks (task segmentation) to help him or her cope?
QE Task segmentation - yes G7=1

Comments: triggered 2° ↓ Cognitive Status. resident has had deterioration Cog status- requires more assist Decision making Patient with resolving delirium. patient requires orientation to ability. will care plan to monitor resolving delirium & Mental status.

Proceed with Care Plan: Yes ✓ No
Signature: [signature] Date: 01/31/03

Resident Name: RUNGE, HELEN
Resident Number: 3-0012-0 Room: 365-A
Assessment Date: 01/29/2003 Ver: Rsn: 01

COG. LOSS/DEMENTIA RAP Code: 002

** RAP Key Summary **

Assess/ ICD-9	Description	MDS Cde
1:	*Consider if cognitive loss/dementia is related to neurological conditions.	
QF	No MR/DD conditions	AB10a
GQ	Disord. thinking-changing awareness of environment	B5b
GT	Cognitive ability varies over course of day	B5f
N6	Cognitive status, skills, abilities - deteriorated	B6=2
FC	Dementia not Alzheimer's	I1u
2:	*Consider other confounding problems which may require resolution or suggest reversible causes: Mood & Behavior.	
Hn	Repetitive anxious complaints/concerns	E1i
H4	Repetitive physical mvmts handwringing, pacing, etc	E1n
Hs	Mood persistence: indictr present, easily altered	E2=1
ND	Mood - no change	E3=0
V2	Wandering: 1-3 days Not present/easily altrd	E4aA=1
V5	Verbally abusive: not Not present/easily altrd	E4bA=0
V9	Physically abusive: not Not present/easily altrd	E4cA=0
VD	Socially inappr beh: not Not present/easily altrd	E4dA=0
VH	Resists care: not exhbtd. Not present/easily altrd	E4eA=0
NG	Problem behavioral signs- no change	E5-0
IB	Depression	I1ee
IG	Delusions	J1g
3:	*Consider confounding medical problems that may require resolution or suggest reverible causes.	
Ob	Pain frequency - pain less than daily	J2a=1
Oe	Pain intensity - moderate	J2b=2
4:	*Consider if failure to thrive is a confounding problem that may require resolution or suggest reversible causes.	
M3	Height (in inches) 64	K2a
M1	Weight 103	K2b
Bn	No weight loss	K3a=0
Qk	Res. self sufficiency - deteriorated	Q2=2
5:	*Consider if functional limitations is a confounding problem that may require resolution or suggest reversible causes.	
61	Positioning-Independent No setup/physical help	G1a=0
81	Transfer-Independent No setup/physical help	G1b=0
T6	In room - Independent No setup/physical help	G1c=0

Resident Name: RUNGE, HELEN
Resident Number: 3-0012-0 Room: 365-A
Assessment Date: 01/29/2003 Ver: Rsn: 01

COG. LOSS/DEMENTIA RAP Code: 002

** RAP Key Summary **

Assess/ ICD-9	Description	MDS Cde
TB	In corridor-independent No setup/physical help	G1d=0
11	Locom. on unit-Independ. Setup help only	G1e=0
1C	Locom. off unit-Indepent. Setup help only	G1f=0
33	Dressing-Limited Assist 1 person physical assist	G1g=2
41	Eating - Independent No setup/physical help	G1h=0
71	Toileting-Independent No setup/physical help	G1i=0
51	Hygiene-Independent Setup help only	G1j=0
QE	Task segmentation - yes	G7=1
N9	ADL function-deteriorated DETERIORATED	G9=2
NA	Urinary continence - no change	H4=0

6: *Consider if sensory impairment is a confounding problem that may require resolution or suggest reversible causes.

K2	Hearing - min. difficulty when not in quiet setting	C1=1
GU	Speech clear	C5=0
GF	Usually understands verbal information	C6=1
K8	Vision-impaired-sees large, not regular print	D1=1

7. *Consider if medications are a confounding problem that may require resolution or suggest reversible causes.

MQ	Antipsychotics 7 days	O4a

8: Involvement factors to consider:

9: Is resident a new admission to this facility? (record review)

10: *Has resident withdrawn from activities of interest?

11: *Does resident participate in small group activities? (also requires record review)

P8	Preferred act. setting: day/activity room	N3b

12: *Does staff or resident believe that resident can be more independent in at least some ADLs?

Q9	Staff believes res. capable of inc. ind. ADLs	G8b

13: *Consider if use of physical restraints has contributed to resident congnitive decline?

Resident Name: RUNGE, HELEN
Resident Number: 3-0012-0 Room: 365-A
Assessment Date: 01/29/2003 Ver: Rsn: 01

COG. LOSS/DEMENTIA RAP Code: 002

** RAP Key Summary **

Assess/ ICD-9 Description MDS Cde

Comments: Triggered 2° STM loss & 2° Cog loss. Patient required some difficulty in decision making. Patient disoriented x1 (time & location). Goals of will C.P. to improve orientation.

Proceed with Care Plan: Yes ✓ No

Signature: Edwardson Date: 1/31/03

Resident Name: RUNGE, HELEN
Resident Number: 3-0012-0 Room: 365-A
Assessment Date: 01/29/2003 Ver: Rsn: 01

VISUAL FUNCTION RAP Code: 003

** RAP Key Summary **

Assess/ ICD-9	Description	MDS Cde
1:	Is resident receiving eye medications? (Assess effectiveness and presence of side effects)	
2:	*Consider if medical diagnoses or other physiological conditions contribute to impaired visual function.	
3:	*Consider if neurological diagnoses or dementia contribute to impaired visual function.	
	FC Dementia not Alzheimer's	I1u
4:	Has resident received opthamology exam since problem first identified? (record review)	
5:	*Consider if indicators of depression, anxiety, sad mood contribute to impaired visual function.	
	Hn Repetitive anxious complaints/concerns	E1i
	H4 Repetitive physical mvmts handwringing, pacing, etc	E1n
6:	*Does resident use visual appliances appropriately? (also requires record review and observation)	
	KB Wears glasses/contact lens/magnifying glass	D3=1
7:	Is there a functional need for an eye exam and or new glasses? (from observation)	
8:	Consider if environmental modifications would improve visual function - e.g., low glare surfaces, night lights, etc.	
9:	Is resident experiencing other acute problems, e.g., eye pain, blurry vision double vision, sudden loss of vision.	

Comments: 1/03 read 20/ visual acuity. Patient able to read large print with glasses. Patient has a visual limitation/difficulties. Currently slight visual difficulty does not interfere with functional activities

Proceed with Care Plan: Yes X No

Signature: [signature] Date: 1/31/03

SUNBRIDGE C & R RANDOLPH

01/30/03 11:42 RESIDENT ASSESSMENT PROTOCOL REPORT PAGE 1

Resident Name: RUNGE, HELEN
Resident Number: 3-0012-0 Room: 365-A
Assessment Date: 01/29/2003 Ver: Rsn: 01

COMMUNICATION RAP Code: 004

** RAP Key Summary **

Assess/ ICD-9	Description	MDS Cde
1:	*Consider if change in cognitive, mood and ADL status are confounding problems that may require resolution.	
	N6 Cognitive status, skills, abilities - deteriorated	B6=2
	ND Mood - no change	E3=0
	N9 ADL function-deteriorated DETERIORATED	G9=2
2:	Which of the following components of communication are weaknesses and which are strengths to build upon?	
3:	*Hearing:	
	K2 Hearing - min. difficulty when not in quiet setting	C1=1
4:	Is there a need for audiology exam?	
5	*Communication devices or modes of expression:	
	Kk Communication devices/ techniques: None	C2d
	KI Modes of expression: speech	C3a
6:	Is there a need for speech evaluation?	
7:	*Decline in communication or hearing:	
	N1 Ability to express/hear/ understand - no change	C7=0
8:	*Vision:	
	K8 Vision-impaired-sees large, not regular print	D1=1
9:	Is there a need eye exam?	
10:	Consider medical status of ear - discharges, cerumen accumulation, hearing changes. (record review)	
11:	*Consider if chronic conditions affect resident's communication.	

Resident Name: RUNGE, HELEN
Resident Number: 3-0012-0 Room: 365-A
Assessment Date: 01/29/2003 Ver: Rsn: 01

COMMUNICATION RAP Code: 004

** RAP Key Summary **

Assess/ ICD-9	Description	MDS Cde
FC	Dementia not Alzheimer's	I1u
IB	Depression	I1ee

12: *Consider if transitory conditions affect resident's communication.

NG	Problem behavioral signs- no change	B5=0
Li	Infections: None	I2m

13: *Consider if use of psychotrophic medications affects resident's communication.

MQ	Antipsychotics 7 days	O4a

14: Consider if narcotics, Parkinson's meds, aspirin toxicity, Tobramycin, Gentamycin affects communication (record review)

15: Consider if quality or quantity of communication is/is not commensurate with apparent ability to communicate. (staff)

16. *Consider if resident has a memory deficit which affects communication.

G6	Memory deficit-Short term (no recall after 5 min.)	B2a=1
Gh	Long-term memory: ok	B2b=0
G1	Resident able to recall current season	B3a
G2	Resident able to recall location of own room	B3b
G3	Resident able to recall staff names/faces	B3c
G4	Resident able to recall that he/she is in SNF	B3d

17: *Has resident received recent audiology/language pathology evaluation?

MG	SPEECH/AUDIOLOGY 0235	P1ba

18: *Has resident's condition deteriorated since last assessment?

Qk	Res. self sufficiency - deteriorated	Q2=2

Comments: Triggered 20 V functional communication
unable to make needs/wants known
patient has V hearing acuity. ∅ communicative devices
needed. need C.P. for management

Proceed with Care Plan: Yes ✓ No
Signature: Edna Randolph Date: 1/31/03

Resident Name: RUNGE, HELEN
Resident Number: 3-0012-0 Room: 365-A
Assessment Date: 01/29/2003 Ver: Rsn: 01

ADL FUNCTIONAL REHAB RAP Code: 005

** RAP Key Summary **

Assess/ ICD-9	Description	MDS Cde
1:	Consider confounding problems that may require resolution before rehab goals can be reasonably attempted:	
2:	*Delirium:	
GQ	Disord. thinking-changing awareness of environment	B5b
GT	Cognitive ability varies over course of day	B5f
3:	*Persistent mood problem:	
Hs	Mood persistence: indictr present, easily altered	E2=1
4:	*Decline in mood:	
ND	Mood - no change	E3=0
5	*Daily behavioral symptoms:	
V2	Wandering: 1-3 days Not present/easily altrd	E4aA=1
V5	Verbally abusive: not Not present/easily altrd	E4bA=0
V9	Physically abusive: not Not present/easily altrd	E4cA=0
VD	Socially inappr beh: not Not present/easily altrd	E4dA=0
VH	Resists care: not exhbtd. Not present/easily altrd	E4eA=0
6:	*Decline in behavioral symptoms:	
NG	Problem behavioral signs- no change	E5=0
7:	*Unstable or acute health problems:	
QY	Cond. making res unstable	J5a
8:	*Use of psychoactive medications:	
MQ	Antipsychotics 7 days	O4a
9:	*Resident status deteriorated since last assessment:	
Qk	Res. self sufficiency - deteriorated	Q2=2
10:	Consider clarifying issues to determine the resident's potential for improved functioning.	

Resident Name: RUNGE, HELEN
Resident Number: 3-0012-0 Room: 365-A
Assessment Date: 01/29/2003 Ver: Rsn: 01

ADL FUNCTIONAL REHAB RAP Code: 005

** RAP Key Summary **

Assess/ ICD-9	Description	MDS Cde
11: *Ability to make decisions:		
GM	Decisions-Mod Independent difficulty-new situations	B4=1
12: *Prior improvement in cognition, mood, behavior, or ADLs:		
N6	Cognitive status, skills, abilities - deteriorated	B6=1
ND	Mood - no change	E3=0
NG	Problem behavioral signs- no change	E5=0
N9	ADL function-deteriorated DETERIORATED	G9=2
13: *Communication:		
K2	Hearing - min. difficulty when not in quiet setting	C1=1
Kk	Communication devices/ techniques: None	C2d
KI	Modes of expression: speech	C3a
G8	Communicates w/o any limitations-understood	C4=0
GU	Speech clear	C5=0
GF	Usually understands verbal information	C6=1
N1	Ability to express/hear/ understand - no change	C7=0
14: *Vision:		
K8	Vision-impaired-sees large, not regular print	D1=1
KB	Wears glasses/contact lens/magnifying glass	D3=1
15: *Test for balance, functional limitation in range of motion:		
1I	Balance while standing: Maintained Position	G3a
1J	Balance while sitting: Maintained Position	G3b
6a	ROM-Neck: no limitation No loss	G4aA=0
6d	ROM-ARM:No limitation No loss	G4bA=0
6g	ROM-HAND:No limitation No loss	G4cA=0
6j	ROM-LEG:No limitation	G4dA=0
6m	ROM-FOOT:No limitation	G4eA=0
6p	ROM-OTHR:No limitation	G4fA=0
16: *Staff or resident believe resident could be more independent in at least some ADLs:		
Q9	Staff believes res. capable of inc. ind. ADLs	G8b

Resident Name: RUNGE, HELEN
Resident Number: 3-0012-0 Room: 365-A
Assessment Date: 01/29/2003 Ver: Rsn: 01

ADL FUNCTIONAL REHAB RAP Code: 005

** RAP Key Summary **

Assess/ ICD-9	Description	MDS Cde

17: Complete ADL supplement part 1 for all triggered residents.

18: Complete ADL supplement part 2 for residents with rehabilitation potential.

Comments: Triggered 2° V ADL function 2° deconditioning 2° Hospitalization + dx MS AS c delusion, paranoia, anemia. Rehab potential good. refer to PT/OT notes + C.P. to improve functional status.

Proceed with Care Plan: Yes ✓ No

Signature: S Edmundson Date: 1/31/03

Resident Name: RUNGE, HELEN
Resident Number: 3-0012-0 Room: 365-A
Assessment Date: 01/29/2003 Ver: Rsn: 01

PSYCHOSOC WELL BEING RAP Code: 007

** RAP Key Summary **

Assess/ ICD-9	Description	MDS Cde
	1: Consider confounding problems which may affect resident's psychosocial well-being:	
	2: *Increasing/persistent sad mood:	
Hs	Mood persistence: indictr present, easily altered	E2=1
ND	Mood - no change	E3=0
	3: *Increasing or daily disturbing behavior:	
V2	Wandering: 1-3 days Not present/easily altrd	E4aA=1
V5	Verbally abusive: not Not present/easily altrd	E4bA=0
V9	Physically abusive: not Not present/easily altrd	E4cA=0
VD	Socially inappr beh: not Not present/easily altrd	E4dA=0
VH	Resists care: not exhbtd. Not present/easily altrd	E4eA=0
NG	Problem behavioral signs- no change	E5=0
	4. *Resident's condition deteriorated since last assessment:	
Qk	Res. self sufficiency - deteriorated	Q2=2
	5: Consider situational factors that may impede ability to interact with others	
	6: *Loss of family member, friend, or staff close to resident (MDS and record review)	
	7: *Initial use of physical restraints	
LL	Other type of side rails Used daily	P4b
	8: New admission, change in room assignment, or change in dining location or table mates (record review)	
	9: Consider resident characteristics that may impede ability to interact with others.	
	10: *Delirium or cognitive decline:	
GQ	Disord. thinking-changing awareness of environment	B5b

Resident Name: RUNGE, HELEN
Resident Number: 3-0012-0 Room: 365-A
Assessment Date: 01/29/2003 Ver: Rsn: 01

PSYCHOSOC WELL BEING RAP Code: 007

** RAP Key Summary **

Assess/ ICD-9	Description	MDS Cde
GT	Cognitive ability varies over course of day	B5f
N6	Cognitive status, skills, abilities - deteriorated	B6=2

11: *Communication deficit or decline:

G8	Communicates w/o any limitations-understood	C4=0
GU	Speech clear	C5=0
GF	Usually understands verbal information	C6=1
N1	Ability to express/hear/ understand - no change	C7=0

12: *Not at ease interacting with others: (F1a not checked)

PM	At ease interacting with others	F1a

13: *Locomotion deficit or use of wheelchair:

T6	In room - Independent No setup/physical help	G1cA=0
TB	In corridor-independent No setup/physical help	G1dA=0
11	Locom. on unit-Independ. Setup help only	G1eA=0
1C	Locom. off unit-Indepent. Setup help only	G1fA=0

14: *Diseases that impede communication:

QF	No MR/DD conditions	AB10a
FC	Dementia not Alzheimer's	I1u
IB	Depression	I1ee

15: *Uninvolved in activities:

P2	Average time involved in activities-some of time	N2=1

16: Consider lifestyle issues which may affect resident's psychosocial well-being:

17: *Incongruence of current and prior style of life:

R1	Stays up late at night (after 9 PM)	AC1a
R2	Naps regularly during day (at least 1 hour)	AC1b
R4	Busy with hobbies, read- ing, fixed daily routine	AC1d
R6	Moves independently in- doors w/appliance if used	AC1f
RC	Eating patterns: None	AC1l

Resident Name: RUNGE, HELEN
Resident Number: 3-0012-0 Room: 365-A
Assessment Date: 01/29/2003 Ver: Rsn: 01

PSYCHOSOC WELL BEING RAP Code: 007

** RAP Key Summary **

Assess/ ICD-9		Description	MDS Cde
	RI	Hygiene patterns: None	AC1r
	RN	Involved in group activities	AC1w

18: *Strong identification with past roles or status:

19: Length of time problem existed (record review)

20: Consider additional information to clarify nature of the problem.

21: Resident's ability to relate to others; skill or unease in dealing with others, friendly or unapproachable, etc.

22: Consider relationships resident could draw on, supported or isolated, many friends or friendless.

23: Consider resident's ability to deal with grief, moving thru grief or bitter and inconsolable, religious faith.

Comments: Resident triggers under Psycho-social well being due to establishing [illegible] goals. This is a positive activity, no need to care plan.

Proceed with Care Plan? Yes ____ No ✓
Signature: [signature] LCSW Date: 1/30/03

Resident Name: RUNGE, HELEN
Resident Number: 3-0012-0 Room: 365-A
Assessment Date: 01/29/2003 Ver: Rsn: 01

MOOD STATE RAP Code: 008

** RAP Key Summary **

Assess/ ICD-9	Description	MDS Cde
1:	Consider indicators which may suggest the need for a new or altered care stategy.	
2:	*Mood decline:	
	ND Mood - no change	E3=0
3:	*Mood unimproved and reversible conditions present:	
	ND Mood - no change	E3=0
	GQ Disord. thinking-changing awareness of environment	B5b
	GT Cognitive ability varies over course of day	B5f
	N6 Cognitive status, skills, abilities - deteriorated	B6=2
	IG Delusions	J1e
	N9 ADL function-deteriorated DETERIORATED	G9=2
4	Recent move into or within facility	
5:	Use of meds known to cause mood shifts: antihypertensives, cimetidine, clonidine, cytoxic agents digitalis (cont.)	
6:	guanethidine, immunosuppressive, methyldopa, nitrates, propranolol, reserpine, steroids, stimulants (record review)	
7:	*Mood unimproved & indication of problem with cognitive ability/memory decision-making ability/ability to understand	
	ND Mood - no change	E3=0
	G6 Memory deficit-Short term (no recall after 5 min.)	B2a=1
8:	Consider the following in relation to unimproved mood and problem w/cognition, memory, deicision making, understanding	
9:	*Does resident show little or no initiative?	
10:	*Does resident show little or no involvement in activities?	
11:	*Is resident receiving psychotropic medications and/or psychosocial therapy?	

Resident Name: RUNGE, HELEN
Resident Number: 3-0012-0 Room: 365-A
Assessment Date: 01/29/2003 Ver: Rsn: 01

MOOD STATE RAP Code: 008

** RAP Key Summary **

Assess/ ICD-9		Description	MDS Cde
	MQ	Antipsychotics 7 days	O4a
	MH	PSYCHOLOGICAL THERAPY 0000	P1be

12: *Behavioral or relationship problems present:

	V2	Wandering: 1-3 days Not present/easily altrd	E4aA=1

13: Consider the following confounding issue that may affect mood problems.

14: *Communication skills:

15: *Diseases:

	91	Hypertension	I1h
	FC	Dementia not Alzheimer's	I1u
	IB	Depression	I1ee

16: Additional diseases-other psychosis, hypercalcemia, Cushings Addison's, hypoglycemia, hypokalemia, porphyria (record)

Comments: Resident triggered under mood state d/t to [illegible] [illegible] concerns & complaints & [illegible] symptoms exacerbated by diagnosis of dementia.

Proceed with Care Plan: Yes ✓ No ____
Signature: [illegible], LCSW Date: 1/30/03

00421

Resident Name: RUNGE, HELEN
Resident Number: 3-0012-0 Room: 365-A
Assessment Date: 01/29/2003 Ver: Rsn: 01

BEHAVIORAL SYMPTOMS RAP Code: 009

** RAP Key Summary **

Assess/ ICD-9	Description	MDS Cde
1:	*Consider seriousness & stability or change of behavioral symptoms ie; intensity, duration, frequency, pattern, effect	
	V2 Wandering: 1-3 days Not present/easily altrd	E4aB
2:	Consider the following potential causes that may affect resident's behavioral symptoms.	
3:	*Cognitive status problems:	
	GQ Disord. thinking-changing awareness of environment	B5b
	GT Cognitive ability varies over course of day	B5f
	FC Dementia not Alzheimer's	I1u
4:	*Mood or relationship problems:	
	H4 Repetitive physical mvmts handwringing, pacing, etc	E1n
	IB Depression	I1ee
5:	*Environmental conditions - resident's daily routine is different from prior pattern in community	
6:	Environmental conditions - does noise, crowding or dimly lit areas affect behavior? (observation and record review)	
7:	Environmental conditions - are other resident's physically agressive? (observation and record review)	
8:	*Illness and conditions:	
	QY Cond. making res unstable	J5a
	IG Delusions	J1e
	Ob Pain frequency - pain less than daily	J2a=1
	Oe Pain intensity - moderate	J2b=2
9:	*Sensory impairments:	
10:	*Treatment and management procedures:	
	MQ Antipsychotics 7 days	O4a

Resident Name: RUNGE, HELEN
Resident Number: 3-0012-0 Room: 365-A
Assessment Date: 01/29/2003 Ver: Rsn: 01

BEHAVIORAL SYMPTOMS RAP Code: 009

** RAP Key Summary **

Assess/ ICD-9	Description	MDS Cde
On	Eval by license mental hlth spclst. last 90 days	P2b
Oq	Reorientation (e.g., cueing)	P2e

Comments: Resident triggered under behavioral symptoms due to unclear symptoms exacerbated by diagnosis of Dementia.

Proceed with Care Plan: Yes ✓ No
Signature: Kathleen Snider, LCSW Date: 1/30/03

Resident Name: RUNGE, HELEN
Resident Number: 3-0012-0 Room: 365-A
Assessment Date: 01/29/2003 Ver: Rsn: 01

FALLS RAP Code: 011

** RAP Key Summary **

Assess/ ICD-9	Description	MDS Cde
1:	Consider the following risk factors for falls in identifying problems that may be addressed or resolved.	
2:	*Multiple falls:	
3:	*Internal Risk Factors - Cardiovascular, Neuromuscular or functional, orthopedic, perceptual, psychiatric/cognitive:	
	N9 ADL function-deteriorated DETERIORATED	G9=2
	QY Cond. making res unstable	J5a
	K8 Vision-impaired-sees large, not regular print	D1=1
	GQ Disord. thinking-changing awareness of environment	B5b
	GT Cognitive ability varies over course of day	B5f
	N6 Cognitive status, skills, abilities - deteriorated	B6=2
	FC Dementia not Alzheimer's	I1u
4	Consider the following external risk factors.	
5:	*Medications: *Psychotropic meds, cardiovascular meds and *diuretics (*MDS and record review)	
	MQ Antipsychotics 7 days	O4a
6:	*Appliances and devices: pacemaker/*cane/*walker/*crutch, devices and *restraints (*MDS and record review)	
	LL Other type of side rails Used daily	P4b
7:	Review environmental hazards: glare; poor illumination, slippery floors, foreignm objects in walkway.	
8:	Review situational hazards: time of day, time since meal, type of activity, responding to bladder or bowel urgency.	

Comments: Ø Ingested 20 psychotropic meds use Hx depression, psychotropic drug use. Patient gait slightly unsteady. will add plan for safety

Proceed with Care Plan: Yes No
Signature: Helen Randolph Date: 1/31/03

Resident Name: RUNGE, HELEN
Resident Number: 3-0012-0 Room: 365-A
Assessment Date: 01/29/2003 Ver: Rsn: 01

PSYCHOTROPIC DRUG RAP Code: 017

** RAP Key Summary **

Assess/ ICD-9	Description	MDS Cde
1:	Conduct psychotropic drug review to determine the following information:	
2:	Length of time between onset of problem and when drug was first given (record review)	
3:	Dosage and frequency of administration of drug.	
4:	Number of classes of psychotropics taken.	
5:	Reason psychotropic drug was prescribed.	
6:	*Review conditions that affect drug metabolism or excretion- impaired liver/renal function, acute condition, dehydration.	
7:	*Review behavior, mood and psychiatric status:	
	Hn Repetitive anxious complaints/concerns	E1i
	H4 Repetitive physical mvmts handwringing, pacing, etc	E1n
	MH PSYCHOLOGICAL THERAPY 0000	P1be
	On Eval by license mental hlth spclst. last 90 days	P2b
	Oq Reorientation (e.g., cueing)	P2e
	IB Depression	I1ee
8:	Consider clarifying information if hypotension present.	
9:	Does resident have postural changes in vital signs? (exam)	
10:	Is resident receiving marked anticholinergic properties? (record review)	
11:	Consider clarifying information if movement disorder present.	
12:	*High fever:	

Resident Name: RUNGE, HELEN
Resident Number: 3-0012-0 Room: 365-A
Assessment Date: 01/29/2003 Ver: Rsn: 01

PSYCHOTROPIC DRUG RAP Code: 017

** RAP Key Summary **

Assess/ ICD-9	Description	MDS Cde
13:	Muscular rigidity (observation, record review):	
14:	Hand tremors, pill-rolling of hands (observation, record review)	
15:	*Parkinson's disease:	
16:	Marked decrease in spontaneous movement (Akinesia) (observation, record review)	
17:	Rigid, unnatural, uncomfortable posture of neck or trunk (Dystonia) (observation, record review)	
18:	Restlessness, inability to sit still (Akathisia) (observation, record review)	
19:	Persistent movements of mouth, peculiar/recurrent postures of limbs, trunk (Tardive Dyskinesia) (observation record rev)	
20:	Consider clarifying information if gait disturbances present.	
21:	Long-acting benzodiazepines, recent dosage increase (record review)	
22:	*Short-term memory loss, decline in cognition, slurred slurred speech:	
	G6 Memory deficit-Short term (no recall after 5 min.)	B2a=1
	N6 Cognitive status, skills, abilities - deteriorated	B6=2
23:	*Decreased daytime wakefulness, little or no activity involvement:	
	PW Morning-res awake most of time-naps less than 1 hr.	N1a
24:	Consider clarifying information if cognitive or behavioral impairment present.	
25:	*If resident does not experience indicators of delirium or depression, drug side effects can be considered a problem.	

Resident Name: RUNGE, HELEN
Resident Number: 3-0012-0 Room: 365-A
Assessment Date: 01/29/2003 Ver: Rsn: 01

PSYCHOTROPIC DRUG RAP Code: 017

** RAP Key Summary **

Assess/ ICD-9	Description	MDS Cde
GQ	Disord. thinking-changing awareness of environment	B5b
GT	Cognitive ability varies over course of day	B5f
IB	Depression	I1ee

26: Consider clarifying issues if drug-related discomfort present.

27: *Dehydration, constipation, fecal impaction:

28: Reduced dietary bulk, lack of exercise, urinary retention, dry mouth (record review)

Comments: triggered 2° Psychotropic drug use
Hx depression, MSAS c delusion, paranoia, patient tolerating current drugs & adverse effects. w/in care plan for therapeutic effectiveness & pdt - S.E.

Proceed with Care Plan: Yes V No
Signature: S Edwards Date: 1/31/03

P01/30/03 11:42 SUNBRIDGE C & R RANDOLPH Resident: 3-0012-0 RUNGE, HELEN

1. Check if RAP is Triggered.
2. For each triggered RAP, use the RAP guidelines to identify areas needing further assessment. Document relevant assessment information regarding the resident's status.
   *Describe:
   -Nature of the condition (may include presence or lack of objective data and subjective complaints).
   -Complications and risk factors that affect your decision to proceed to care planning.
   -Factors that must be considered in developing individualized care plan interventions.
   -Need for referrals/further evaluation by appropriate health professionals.
   *Documentation should support your decision-making regarding whether to proceed with a care plan for a triggered RAP and the type(s) of care plan interventions that are appropriate for a particular resident.
   *Documentation may appear anywhere in the clinical record (e.g., progress notes, consults, flowsheets, ect.).
3. Indicate under the Location of RAP Assessment Documentation column where information related to the RAP assessment care be found.
4. For each triggered RAP, indicate whether a new care plan, care plan revision, or continuation of the current care plan is necessary to address the problem(s) identified in your assessment. The Care Planning Decision column must be completed within 7 days of completing the RAI (MDS and RAPs).

P A. RAP Problem Area	(a) Check if Triggered	Location and Date of RAP Assessment Documentation	(b) Care Planning Decision-check if addressed in care plan
1. Delirium	X	SEE RAP	X
2. Cognitive Loss	X	SEE RAP	X
3. Visual Function	X	SEE RAP	
4. Communication	X	SEE RAP	X
5. ADL Functional/ Rehabilitation Potential	X	SEE RAP	X
6. Urinary Incontinence And Indwelling Cathet			
7. Psychosocial Well-Being	X	SEE RAP	
8. Mood State	X	SEE RAP	X
9. Behavioral Symptoms	X	SEE RAP	X
10. Activities			
11. Falls	X	SEE RAP	X
12. Nutritional Status			
13. Feeding Tubes			
14. Dehydration/Fluid Maintenance			
15. Dental Care			
16. Pressure Ulcers			
17. Psychotropic Drug Use	X	SEE RAP	X
18. Physical Restraints			

B. [signature] 01/31/2003 [signature] 01/30/02

P1. Signature of RN Coordinator for RAP Assessment Process 3. Signature of Person Completing Care Planning Decision

MINIMUM DATA SET (MDS) -- VERSION 2.0
FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING
BACKGROUND (FACE SHEET) INFORMATION AT ADMISSION

SECTION AA. IDENTIFICATION INFORMATION

1.	RESIDENT NAME	RUNGE, HELEN	
2.	GENDER	1. Male 2. Female	2
3.	BIRTHDATE	08/03/1915	
4.	RACE/ ETHNICITY	1. American Indian/Alaskan Native 2. Asian/Pacific Islander 3. Black, not of Hispanic Origin 4. Hispanic 5. White, not of Hispanic origin	5
5.	SOCIAL SECURITY AND MEDICARE NUMBERS [C in 1st box if non med. no.]	a. Social Security Number 023-05-1066 b. Medicare number (or comparable railroad insurance number) 023051066A	
6.	FACILITY PROVIDER NO.	a. State No. 0927554 b. Federal No. 225356	
7.	MEDICAID NO. ["+" if pending, "N" if not a Medicaid recipient]	N	
8.	REASONS FOR ASSESSMENT	a. Primary reason for assessment 1. Admission Assessment (required by day 14) 2. Annual Assessment 3. Significant change in status assessment 4. Significant correction of prior assessment 5. Quarterly review assessment 10. Significant correction of prior quarterly assessment 0. NONE OF ABOVE	01
		b. Codes for assessments required for Medicare PPS or the State 1. Medicare 5 day assessment 2. Medicare 30 day assessment 3. Medicare 60 day assessment 4. Medicare 90 day assessment 5. Medicare readmission/return assessment 6. Other state required assessment 7. Medicare 14 day assessment 8. Other Medicare required assessment	1

9.	Signatures of Persons who Completed a Portion of the Accompanying Assessment or Tracking Form	
	I certify that the accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.	
	Signature and Title	Sections / Date
a.	Susan Ridley LCSW RAC-CT RP	1/30/03
b.	[illegible] MSC RN	1-30-03
c.	Sonia Edwards LNA except AE #10	1/30/03
d.	Nandita Singh OTR/L T.P	1/31/03
e.		
f.		
g.		
h.		
i.		
j.		
k.		
l.		

SECTION AB. DEMOGRAPHIC INFORMATION

1.	DATE OF ENTRY	Date the stay began. Note - Does not include readmission if record was closed at time of temporary discharge to hospital, etc. In such cases, use prior admission date. 01/22/2003	
2.	ADMITTED FROM (AT ENTRY)	1. Private home/apt. with no home health services 2. Private home/apt. with home health services 3. Board and care/assisted living/group home 4. Nursing home 5. Acute care hospital 6. Psychiatric hospital, MR/DD facility 7. Rehabilitation hospital 8. Other	5
3.	LIVED ALONE (PRIOR TO ENTRY)	0. No 1. Yes 2. In other facility	0
4.	ZIP CODE OF PRIOR PRIMARY RESIDENCE	02127	
5.	RESIDENTIAL HISTORY 5 YEARS PRIOR TO ENTRY	(Check all settings resident lived in during 5 years prior to date of entry given in item AB1 above) a. Prior stay at this nursing home b. Stay in other nursing home c. Other residential facility-board and care home, assisted living, group home d. MH/psychiatric setting e. MR/DD setting f. NONE OF ABOVE	a. b. ✓ c. ✓ d. e. f.

Resident: RUNGE, HELEN Numeric Identifier: 3-0012-0

SECTION AB. DEMOGRAPHIC INFORMATION

6.	LIFETIME OCCUPATION(S) [Put "/" between two occupations]	UNKNOWN	
7.	EDUCATION (Highest Level Completed)	1. No schooling 2. 8th grade/less 3. 9-11 grades 4. High school 5. Technical or trade school 6. Some college 7. Bachelor's degree 8. Graduate degree	4
8.	LANGUAGE	(Code for correct response) a. Primary Language 0. English 1. Spanish 2. French 3. Other b. If other specify	0
9.	MENTAL HEALTH HISTORY	Does resident's RECORD indicate any history of mental retardation, mental illness, or developmental disability problem? 0. No 1. Yes	0
10.	CONDITIONS RELATED TO MR/DD STATUS	(Check all conditions that are related to MR/DD status that were manifested before age 22, and are likely to continue indefinitely) a. Not applicable-no MR/DD (Skip to AB11) MR/DD with organic condition b. Down's syndrome c. Autism d. Epilepsy e. Other organic condition related to MR/DD f. MR/DD with no organic condition	a. ✓ b. c. d. e. f.
11.	DATE BACKGROUND INFORMATION COMPLETED	01/30/2003	

SECTION AC. CUSTOMARY ROUTINE

1.	CUSTOMARY ROUTINE (In year prior to DATE OF ENTRY to this nursing home, or year last in community if now being admitted from another nursing home)	(Check all that apply. If all information UNKNOWN, check last box only.) CYCLE OF DAILY EVENTS a. Stays up late at night (e.g. after 9pm) b. Naps regularly during day (at least 1 hour) c. Goes out 1+ days a week d. Stays busy with hobbies, reading, or fixed daily routine e. Spends most of time alone or watching TV f. Moves independently indoors (with appliances if used) g. Use of tobacco products at least daily h. NONE OF ABOVE	a. ✓ b. ✓ c. d. ✓ e. f. ✓ g. h.
		EATING PATTERNS i. Distinct food preferences j. Eats between meals all or most days k. Use of alcoholic beverage(s) at least weekly l. NONE OF ABOVE	i. j. k. l. ✓
		ADL PATTERNS m. In bedclothes much of day n. Wakens to toilet all or most night o. Has irregular bowel movement pattern p. Showers for bathing q. Bathing in PM r. NONE OF ABOVE	m. n. o. p. q. r. ✓
		INVOLVEMENT PATTERNS s. Daily contact with relatives/close friends t. Usually attends church, temple, synagogue (etc.) u. Finds strength in faith v. Daily animal companion/presence w. Involved in group activities x. NONE OF ABOVE	s. t. u. v. w. ✓ x.
		y. UNKNOWN-Resident/family unable to provide information	y.

SECTION AD. FACE SHEET SIGNATURES

SIGNATURES OF PERSONS COMPLETING FACE SHEET:

a. Signature of RN Assessment Coordinator — Date: 1/30/03

I certify that the accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

	Signature and Title	Sections	Date
b.			
c.			
d.			
e.			
f.			
g.			

MINIMUM DATA SET (MDS) -- VERSION 2.0
FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING
FULL ASSESSMENT FORM

SECTION A. IDENTIFICATION AND BACKGROUND

1.	RESIDENT NAME	RUNGE, HELEN	
2.	ROOM NUMBER	365-1	
3.	ASSESSMENT REFERENCE DATE	a. Last day of MDS observation period 01/29/2003 b. Original (0) or corrected copy of form (enter number of correction)	[redacted] [redacted]
4a.	DATE OF REENTRY	Date of reentry from most recent temporary discharge to a hospital in last 90 days (or since last assessment or admission if less than 90 days) / /	
5.	MARITAL STATUS	1. Never married 3. Widowed 5. Divorced 2. Married 4. Separated	5
6.	MEDICAL RECORD NO.	3-0012-0	
7.	CURRENT PAYMENT SOURCES FOR N.H. STAY	(Billing Office to indicate: check all that apply in last 30 days) Medicaid Per Diem a. / VA per diem Medicare Per Diem b.√ / Self or family pays for full per diem Medicare ancillary part A c. / Medicaid resident liability or Medicare co-payment Medicare ancillary part B d. / Private insurance per diem (including co-payment) CHAMPUS per diem e. / Other per diem	f. g. h. i. j.
8.	REASONS FOR ASSESSMENT [Note-If this is a discharge or reentry assessment, only a limited subset of MDS items need be completed]	a. Primary reason for assessment 1. Admission Assessment (required by day 14) 2. Annual Assessment 3. Significant change in status assessment 4. Significant correction of prior assessment 5. Quarterly review assessment 6. Discharged-return not anticipated 7. Discharged-return anticipated 8. Discharged prior to completing initial 9. Reentry 10. Significant correction of prior quarterly assessment 0. NONE OF ABOVE b. Codes for assessments required for Medicare PPS or the State 1. Medicare 5 day assessment 2. Medicare 30 day assessment 3. Medicare 60 day assessment 4. Medicare 90 day assessment 5. Medicare readmission/return assessment 6. Other state required assessment 7. Medicare 14 day assessment 8. Other Medicare required assessment	01 [redacted] 1 [redacted]
9.	RESPONSIBILITY/ LEGAL GUARDIAN	(Check all that apply) a. Legal guardian a. / d. Durable power attorney/financial b. Other legal oversight b. / e. Family member responsible c. Durable power of attorney/health care c.√ / f. Patient responsible for self g. NONE OF ABOVE	d.√ e. f. g.
10.	ADVANCED DIRECTIVES	(For those items with supporting documentation in the medical record, check all that apply) a. Living will a. / f. Feeding restrictions b. Do not resuscitate b. / g. Medication restrictions c. Do not hospitalize c. / h. Other treatment restrictions d. Organ donation d. / i. NONE OF ABOVE e. Autopsy request e.	[redacted] f. g. h. i.√

SECTION B. COGNITIVE PATTERNS

1.	COMATOSE	(Persistent vegetative state/no discernible consciousness.) 0. No 1. Yes (If yes skip to Section G)	[redacted] 0
2.	MEMORY	(Recall of what was learned or known) a. Short-term memory OK - seems/appears to recall after 5 minutes 0. Memory OK 1. Memory problem	[redacted] 1
		b. Long-term memory OK - seems/appears to recall long past. 0. Memory OK 1. Memory problem	[redacted] 0
3.	MEMORY/ RECALL ABILITY	(Check all that resident was normally able to recall during last 7 days) a. Current season b. Location of own room c. Staff names/faces d. That he/she is in a nursing home e. NONE OF ABOVE are recalled	[redacted] a.√ b.√ c.√ d.√ e.
4.	COGNITIVE SKILLS FOR DAILY DECISION-MAKING	(Made decisions regarding tasks of daily life) 0. INDEPENDENT-decisions consistent/reasonable 1. MODIFIED INDEPENDENCE-some difficulty in new situations only 2. MODERATELY IMPAIRED-decisions poor; cues/ supervision required 3. SEVERELY IMPAIRED-never/rarely made decisions	[redacted] 1 [redacted]
5.	INDICATORS OF DELERIUM-PERIODIC DISORDERED THINKING/ AWARENESS	(Code for behavior in the last 7 days.) [Note: Accurate assessment requires conversations with staff and family who have direct knowledge of resident's behavior over this time.] 0. Behavior not present 1. Behavior present, not of recent onset 2. Behavior present, over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening)	
		a. EASILY DISTRACTED-(e.g., difficulty paying attention; gets sidetracked)	a.0
		b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS-(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day)	[redacted] b.1
		c. EPISODES OF DISORGANIZED SPEECH-(e.g. speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought)	[redacted] c.0
		d. PERIODS OF RESTLESSNESS-(e.g., fidgeting or picking at skin, clothing, napkins, etc; frequent position changes; repetitive physical movement or calling out)	[redacted] d.0
		e. PERIODS OF LETHARGY-(e.g., sluggishness; staring into space; difficult to arouse; little body movement)	[redacted] e.0
		f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY-(e.g., sometime better, sometimes worse; behaviors sometimes present, sometimes not)	[redacted] f.1
6.	CHANGE IN COGNITIVE STATUS	Resident's cognitive status, skills, or abilities have changed as compared to status 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated	[redacted] 2

SECTION C. COMMUNICATION/HEARING PATTERNS

1.	HEARING	(With hearing appliance, if used) 0. HEARS ADEQUATELY-normal talk, TV, phone 1. MINIMAL DIFFICULTY when not in quiet setting 2. HEARS IN SPECIAL SITUATIONS ONLY-speaker has to adjust tonal quality and speak distinctly 3. HIGHLY IMPAIRED/ absence of useful hearing	[redacted] 1 [redacted]
2.	COMMUNICATION DEVICES/ TECHNIQUES	(Check all that apply during the last 7 days) a. Hearing aid, present and used b. Hearing aid, present and not used regularly c. Other receptive comm. techniques used (e.g., lip reading) d. NONE OF ABOVE	a. b. c. d. √
3.	MODES OF EXPRESSION	(Check all used by resident to make needs known) a. Speech b. Writing messages to express or clarify needs c. American sign language or Braille d. Signs/gestures/sounds e. Communication board f. Other g. NONE OF ABOVE	a. √ b. c. d. e. f. g.
4.	MAKING SELF UNDERSTOOD	(Expressing information content - however able) 0. UNDERSTOOD 1. USUALLY UNDERSTOOD-difficulty finding words or finishing thoughts 2. SOMETIMES UNDERSTOOD-ability is limited to making concrete requests 3. RARELY/NEVER UNDERSTOOD	[redacted] 0 [redacted]
5.	SPEECH CLARITY	(Code for speech in the last 7 days) 0. CLEAR SPEECH-distinct, intelligible words 1. UNCLEAR SPEECH-slurred, mumbled words 2. NO SPEECH-absence of spoken words	[redacted] 0
6.	ABILITY TO UNDERSTAND OTHERS	(Understanding verbal information content - however able) 0. UNDERSTANDS 1. USUALLY UNDERSTANDS-may miss some part/ intent of message 2. SOMETIMES UNDERSTANDS-responds adequately to simple, direct communication 3. RARELY/NEVER UNDERSTANDS	[redacted] 1 [redacted]
7.	CHANGE IN COMMUNICATION/ HEARING	Resident's ability to express, understand or hear information has changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No Change 1. Improved 2. Deteriorated	[redacted] 0

Resident: RUNGE, HELEN Numeric Identifier: 3-0012-0

SECTION D. VISION PATTERNS

1.	VISION	(Ability to see in adequate light and with glasses if used) 0. ADEQUATE-sees fine detail, including regular print in newspapers/books 1. IMPAIRED-sees large print, but not regular print in newspapers/books 2. MODERATELY IMPAIRED-limited vision; not able to see newspaper headlines, but can identify objects 3. HIGHLY IMPAIRED-object identification in question, but eyes appear to follow objects. 4. SEVERELY IMPAIRED-no vision or sees only light, colors, or shapes; eyes do not appear to follow objects	1
2.	VISUAL LIMITATIONS/ DIFFICULTIES	a. Side vision problems-decreased peripheral vision (e.g., leaves food on one side of tray, difficulty traveling, bumps into people and objects, misjudges placement of chair when seating self) b. Experiences any of the following: sees halos or rings around lights, sees flashes of light, sees "curtains" over eyes c. NONE OF ABOVE	a. b. c. ✓
3.	VISUAL APPLIANCES	Glasses; contact lenses; magnifying glass 0. No 1. Yes	1

SECTION E. MOOD AND BEHAVIOR PATTERNS

1.	INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD	(Code for indicators observed in last 30 days, irrespective of the assumed cause) 0. Indicator not exhibited in last 30 days 1. Indicator of this type exhibited up to five days a week 2. Indicator of this type exhibited daily or almost daily (6, 7 days a week)	
		VERBAL EXPRESSIONS OF DISTRESS a. Resident made negative statements-e.g., "Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die" b. Repetitive questions-e.g., "Where do I go; What do I do?" c. Repetitive verbalizations-e.g., calling out for help, ("God help me") d. Persistent anger with self or others-e.g., easily annoyed, anger at placement in nursing home; anger at care received e. Self deprecation-e.g., "I am nothing; I am of no use to anyone" f. Expression of what appear to be unrealistic fears-e.g., fear of being abandoned, left alone, being with others g. Recurrent statements that something terrible is about to happen-e.g. believes he or she is about to die, have a heart attack h. Repetitive health complaints-e.g., persistently seeks medical attention, obsessive concern with body functions i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues SLEEP-CYCLE ISSUES j. Unpleasant mood in morning k. Insomnia/change in usual sleep pattern SAD, APATHETIC, ANXIOUS APPEARANCE l. Sad, pained, worried facial expressions-e.g., furrowed brows m. Crying, tearfulness n. Repetitive physical movements-e.g., pacing, hand wringing, restlessness, fidgeting, picking LOSS OF INTEREST o. Withdrawal from activities of interest-e.g., no interest in long standing activities or being with family/friends p. Reduced social interaction	a. 0 b. 0 c. 0 d. 0 e. 0 f. 0 g. 0 h. 0 i. 1 j. 0 k. 0 l. 0 m. 0 n. 1 o. 0 p. 0
2.	MOOD PERSISTENCE	One or more indicators of depressed, sad or anxious mood were not easily altered by attempts to "cheer up", console, or reassure the resident over last 7 days 0. No mood indicators 1. Indicators present, easily altered 2. Indicators present, not easily altered	1
3.	CHANGE IN MOOD	Resident's mood status has changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated	0

			(A)	(B)
4.	BEHAVIORAL SYMPTOMS	(A) Behavioral symptom frequency in last 7 days 0. Behavior not exhibited in last 7 days 1. Behavior of this type occurred 1 to 3 days in last 7 days 2. Behavior of this type occurred 4 to 6 days, but less than daily 3. Behavior of this type occurred daily (B) Behavioral symptom alterability in last 7 days 0. Behavior not present OR behavior was easily altered 1. Behavior was not easily altered		
		a. WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety)	1	0
		b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS(others were threatened, screamed at, cursed at)	0	0
		c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused)	0	0
		d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS (made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding rummaged through others' belongings)	0	0
		e. RESISTS CARE (resisted taking medications, injections, ADL assistance, or eating)	0	0
5.	CHANGE IN BEHAVIORAL SYMPTOMS	Resident's behavior status has changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated	0	

SECTION F. PSYCHOSOCIAL WELL-BEING

1.	SENSE OF INITIATIVE/ INVOLVEMENT	a. At ease interacting with others b. At ease doing planned or structured activities c. At ease doing self-initiated activities d. Establishes own goals e. Pursues involvement in life of facility (e.g., makes/keeps friends; involved in group activities; responds positively to new activities; assists at religious services) f. Accepts invitations to most group activities g. NONE OF ABOVE	a. ✓ b. c. ✓ d. ✓ e. f. g.
2.	UNSETTLED RELATION-SHIPS	a. Covert/open conflict with or repeated criticism of staff b. Unhappy with roommate c. Unhappy with residents other than roommate d. Openly expresses conflict/anger with family/ friends e. Absence of personal contact with family/ friends f. Recent loss of close family member/friend g. Does not adjust easily to change in routines h. NONE OF ABOVE	a. b. c. d. e. f. g. h. ✓
3.	PAST ROLES	a. Strong identification with past roles and life status b. Expresses sadness/anger/empty feeling over lost roles/status c. Resident perceives that daily routine (customary routine, activities) is very different from prior pattern in the community d. NONE OF ABOVE	a. b. c. d. ✓

SECTION G. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS

1. (A) ADL SELF-PERFORMANCE (Code for resident's PERFORMANCE OVER ALL SHIFTS during last 7 days, Not including setup)
0. INDEPENDENT-No help or oversight-OR-Help/oversight provided only 1 or 2 times during last 7 days
1. SUPERVISION-Oversight, encouragement or cueing provided 3 or more times during last 7 days-OR-Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days
2. LIMITED ASSISTANCE-Resident highly involved in activity; received physical help in guided maneuvering of limbs, or other nonweight bearing assistance 3 or more times-OR-More help provided only 1 or 2 times during last 7 days.
3. EXTENSIVE ASSISTANCE-While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:
- Weight-bearing support
- Full staff performance during part (but not all) of last 7 days
4. TOTAL DEPENDENCE-Full staff performance of activity during entire 7 days.
8. ACTIVITY DID NOT OCCUR during entire 7 days.
(B) ADL SUPPORT PROVIDED (Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless of resident's self-performance classification)
0. No setup/physical help from staff
1. Setup help only
2. One person physical assist
3. Two+ persons physical assist
8. ADL activity itself did not occur during entire 7 days

			(A) SELF-PERFORMANCE	(B) SUPPORT
a.	BED MOBILITY	How resident moves to and from lying position, turns side to side, and positions body while in bed.	0	0

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SECTION G. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS

b.	TRANSFER	How resident moves between surfaces-to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)	0	0
c.	WALK IN ROOM	How resident walks between locations in his/her room	0	0
d.	WALK IN CORRIDOR	How resident walks in corridor on unit	0	0
e.	LOCOMOTION ON UNIT	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair	0	1
f.	LOCOMOTION OFF UNIT	How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair	0	1
g.	DRESSING	How resident puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis	2	2
h.	EATING	How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)	0	0
i.	TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes	0	0
j.	PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum. (EXCLUDE baths and showers)	0	1

2. BATHING

How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower. (EXCLUDE washing of back and hair.) Code for most dependent in self-performance and support.)

(A) BATHING SELF PERFORMANCE codes appear below

0. Independent-No help provided
1. Supervision-Oversight help only
2. Physical help limited to transfer only
3. Physical help in part of bathing activity
4. Total dependence
8. Activity itself did not occur during entire 7 days

(Bathing support codes are defined in item 1, code B above)

(A)	(B)
0	1

3. TEST FOR BALANCE (see training manual)

(Code for ability during test in the last 7 days)

0. Maintained position as required in test
1. Unsteady, but able to rebalance self without physical support
2. Partial physical support during test; or stands (sits) but does not follow directions for test
3. Not able to attempt test without physical help

a. Balance while standing	0
b. Balance while sitting-position, trunk control	0

4. FUNCTIONAL LIMITATION IN RANGE OF MOTION (see training manual)

(Code for limitations during last 7 days that interfered with daily functions or placed resident at risk of injury)

(A) RANGE OF MOTION
0. No limitation
1. Limitation on one side
2. Limitation on both sides

(B) VOLUNTARY MOVEMENT
0. No loss
1. Partial loss
2. Full loss

	(A)	(B)
a. Neck	0	0
b. Arm-Including shoulder or elbow	0	0
c. Hand-Including wrist or fingers	0	0
d. Leg-Including hip or knee	0	0
e. Foot-Including ankle or toes	0	0
f. Other limitation or loss	0	0

5. MODES OF LOCOMOTION

(Check all that apply during last 7 days)

a. Cane/walker/crutch	a.
b. Wheeled self	b.
c. Other person wheeled	c.
d. Wheelchair primary mode of locomotion	d.
e. NONE OF ABOVE	e. ✓

6. MODES OF TRANSFER

(Check all that apply during last 7 days)

a. Bedfast all or most of time	a.
b. Bed rails used for bed mobility or transfer	b.
c. Lifted manually	c.
d. Lifted mechanically	d.
e. Transfer aid (e.g., slide board, trapeze, cane, walker, brace)	e.
f. NONE OF ABOVE	f. ✓

7. TASK SEGMENTATION

Some or all of ADL activities were broken into subtasks during last 7 days so that resident could perform them (0. No 1. Yes) — 1

8. ADL FUNCTIONAL REHABILITATION POTENTIAL

a. Resident believes he/she is capable of increased independence in at least some ADLs	a.
b. Direct care staff believe resident is capable of increased independence in a least some ADLs	b. ✓
c. Resident able to perform tasks/activity but is very slow	c. ✓
d. Difference in ADL Self-Performance or ADL support, comparing mornings to evenings	d.
e. NONE OF ABOVE	e.

9. CHANGE IN ADL FUNCTION

Resident's ADL self-performance status has changed as compared to status of 90 days ago (or since last assessment if less than 90 days)
0. No change 1. Improved 2. Deteriorated — 2

SECTION H. CONTINENCE IN LAST 14 DAYS

1. CONTINENCE SELF-CONTROL CATEGORIES

(Code for resident's PERFORMANCE OVER ALL SHIFTS)

0. CONTINENT - Complete control [includes use of indwelling urinary catheter or ostomy device that does not leak urine or stool]
1. USUALLY CONTINENT - BLADDER, incontinent episodes once a week or less; BOWEL, less that weekly
2. OCCASIONALLY INCONTINENT - BLADDER, 2 or more times a week but not daily; BOWEL, once a week
3. FREQUENTLY INCONTINENT - BLADDER, tended to be incontinent daily, but some control present (e.g., on day shift); BOWEL, 2-3 times per week
4. INCONTINENT - Had inadequate control. BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time

a.	BOWEL CONTINENCE	Control of bowel movement, with appliance or bowel continence program, if employed	0
b.	BLADDER CONTINENCE	Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., foley) or continence programs, if employed	0

2. BOWEL ELIMINATION PATTERN

a. Bowel elimination pattern regular-at least one movement every three days	a. ✓
b. Constipation	b.
c. Diarrhea	c.
d. Fecal impaction	d.
e. NONE OF ABOVE	e.

3. APPLIANCES AND PROGRAMS

a. Any scheduled toileting plan	a.
b. Bladder retraining program	b.
c. External(condom) catheter	c.
d. Indwelling catheter	d.
e. Intermittent catheter	e.
f. Did not use toilet room/commode/urinal	f.
g. Pads/briefs used	g.
h. Enemas/irrigation	h.
i. Ostomy present	i.
j. NONE OF ABOVE	j. ✓

4. CHANGE IN URINARY CONTINENCE

Resident's urinary continence has changed as compared to status of 90 days ago (or since last assessment if less than 90 days)
0. No change 1. Improved 2. Deteriorated — 0

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SECTION I. DISEASE DIAGNOSES

Check only those diseases that have a relationship to current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death. (Do not list inactive diagnoses)

1. DISEASES (if none apply, CHECK the NONE OF ABOVE box)

ENDOCRINE/METABOLIC/NUTRITIONAL		Hemiplegia/Hemiparesis	v.
Diabetes mellitus	a.	Multiple sclerosis	w.
Hyperthyroidism	b.	Paraplegia	x.
Hypothyroidism	c.	Parkinson's disease	y.
HEART/CIRCULATION		Quadriplegia	z.
Arteriosclerotic heart disease (ASHD)	d.	Seizure disorder	aa.
Cardiac dysrhythmias	e.	Transient Ischemic attack (TIA)	bb.
Congestive heart failure	f.	Traumatic brain injury	cc.
Deep vein thrombosis	g.	PSYCHIATRIC/MOOD	
Hypertension	h. ✓	Anxiety disorder	dd.
Hypotension	i.	Depression	ee. ✓
Peripheral vascular disease	j.	Manic depression (bipolar disease)	ff.
Other cardiovascular disease	k.	Schizophrenia	gg.
MUSCULOSKELETAL		PULMONARY	
Arthritis	l.	Asthma	hh.
Hip fracture	m.	Emphysema/COPD	ii.
Missing limb (e.g., amputation)	n.	SENSORY	
Osteoporosis	o.	Cataracts	jj.
Pathological bone fracture	p.	Diabetic retinopathy	kk.
NEUROLOGICAL		Glaucoma	ll.
Alzheimer's disease	q.	Macular degeneration	mm.
Aphasia	r.	OTHER	
Cerebral palsy	s.	Allergies	nn.
Cerebrovascular accident (stroke)	t.	Anemia	oo. ✓
Dementia other than Alzheimer's disease	u. ✓	Cancer	pp.
		Renal failure	qq.
		NONE OF ABOVE	rr.

2. INFECTIONS (If none apply CHECK the NONE OF ABOVE box)

a. Antibiotic resistant infection (e.g., Methicillin resistant staph)	a.
b. Clostidium difficile (c. diff.)	b.
c. Conjunctivitis	c.
d. HIV infection	d.
e. Pneumonia	e.
f. Respiratory infection	f.
g. Septicemia	g.
h. Sexually transmitted diseases	h.
i. Tuberculosis	i.
j. Urinary tract infection in last 30 days	j.
k. Viral hepatitis	k.
l. Wound infection	l.
m. NONE OF ABOVE	m. ✓

3. OTHER CURRENT OR MORE DETAILED DIAGNOSES AND ICD-9 CODES

a. OSTEOARTHROSIS-GEN	715.00
b. SENILE DEMENTIA WI	290.20
c. PARANOIA	297.1
d.	
e.	

SECTION J. HEALTH CONDITIONS

1. PROBLEMS CONDITIONS (Check all problems present in the last 7 days unless other time frame is indicated)

INDICATORS OF FLUID STATUS	
a. Weight gain or loss of 3 or more pounds within a 7 day period	a.
b. Inability to lie flat due to shortness of breath	b.
c. Dehydrated; output exceeds input	c.
d. Insufficient fluid; did NOT consume all/almost all liquids provided during last 3 days	d.
OTHER	
e. Delusions	e. ✓
f. Dizziness/Vertigo	f.
g. Edema	g.
h. Fever	h.
i. Hallucinations	i.
j. Internal bleeding	j.
k. Recurrent lung aspirations in last 90 days	k.
l. Shortness of breath	l.
m. Synocope (fainting)	m.
n. Unsteady gait	n.
o. Vomiting	o.
p. NONE OF ABOVE	p.

2. PAIN SYMPTOMS (Check the highest level of pain present in the last 7 days)

a. FREQUENCY with which resident complains or shows evidence of pain
0. No pain (skip to J4) 1. Pain less than daily
2. Pain daily — 1

b. INTENSITY of pain
1. Mild pain 2. Moderate pain
3. Times when pain is horrible or excruciating — 2

3. PAIN SITE (If pain present, check all sites that apply in last 7 days)

a. Back pain	a.	f. Incisional pain	f.
b. Bone pain	b. ✓	g. Joint pain (other than hip	g.
c. Chest pain while doing usual activities	c.	h. Soft tissue pain (e.g. lesion, muscle)	h.
d. Headache	d.	i. Stomach pain	i.
e. Hip pain	e.	j. Other	j.

4. ACCIDENTS (Check all that apply)

a. Fell in past 30 days	a.
b. Fell in past 31-180 days	b.
c. Hip fracture in last 180 days	c.
d. Other fractures in last 180 days	d.
e. NONE OF ABOVE	e. ✓

5. STABILITY OF CONDITIONS

a. Conditions/diseases make resident's cognitive, ADL, mood or behavior patterns unstable (fluctuating, precarious, or deteriorating)	a. ✓
b. Resident experiencing an acute episode or a flare-up of a recurrent or chronic problem	b.
c. End-stage disease, 6 or fewer months to live	c.
d. NONE OF ABOVE	d.

SECTION K. ORAL/NUTRITIONAL STATUS

1. ORAL PROBLEMS

a. Chewing problem	a.	c. Mouth pain	c.
b. Swallowing problem	b.	d. NONE OF ABOVE	d. ✓

2. HEIGHT AND WEIGHT Record (a) height in inches and (b) weight in pounds. Base weight on most recent measure in last 30 days; measure weight consistently in accord with standard facility practice-e.g. in a.m., after voiding, before meal, with shoes off, and in nightclothes.

a. HT(in.) 64
b. WT(lb.) 103

3. WEIGHT CHANGE

a. Weight loss-5% or more in last 30 days or 10% in last 180 days (0. No 1. Yes)	0
b. Weight gain-5% or more in last 30 days or 10% in last 180 days (0. No 1. Yes)	0

4. NUTRITIONAL PROBLEMS

a. Complains about the taste of many foods	a.
b. Regular or repetitive complaints of hunger	b.
c. Leaves 25% or more of food uneaten at most meals.	c.
d. NONE OF ABOVE	d. ✓

5. NUTRITIONAL APPROACHES (Check all that apply in last 7 days)

a. Parenteral/IV	a.
b. Feeding tube	b.
c. Mechanically altered diet	c.
d. Syringe (oral feeding)	d.
e. Therapeutic diet	e.
f. Dietary supplement between meals	f.
g. Plate guard, stabilized built-up utensil, etc.	g.
h. On a planned weight change program	h.
i. NONE OF ABOVE	i. ✓

6. PARENTERAL OR ENTERAL INTAKE (Skip to Section L if neither 5a nor 5b is checked)

a. Code the proportion of total calories the resident received through parenteral or tube feedings in the last 7 days
0. None 2. 26% to 50% 4. 76% to 100%
1. 1% to 25% 3. 51% to 75%

b. Code the average fluid intake per day by IV or tube in the last 7 days.
0. None 3. 1001 to 1500 cc/day
1. 1 to 500 cc/day 4. 1501 to 2000 cc/day
2. 501 to 1000 cc/day 5. 2001 or more cc/day

SECTION L. ORAL/DENTAL STATUS

1. ORAL STATUS AND DISEASE PREVENTION

a. Debris (soft, easily movable substances) present in mouth prior to going to bed at night	a.
b. Has dentures or removable bridge	b.
c. Some/all natural teeth lost-does not have or does not use dentures (or partial plates)	c.
d. Broken, loose, or carious teeth	d.
e. Inflamed gums (gingiva); swollen or bleeding gums; oral abscesses, ulcers or rashes	e.
f. Daily cleaning of teeth/dentures or daily mouth care-by resident or staff	f. ✓
g. NONE OF ABOVE	g.

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SECTION M. SKIN CONDITIONS

1.	ULCERS (Due to any cause)	(Record the number or ulcers at each ulcer stage-regardless of cause. If none present at a stage, record "0" (zero). Code all that apply during last 7 days. Code 9=9 or more.) [Requires full body exam.]	Number at stage
		a. Stage 1. A persistent area of skin redness, (without a break in the skin) that does not disappear when pressure is relieved	0
		b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion blister, or shallow crater	0
		c. Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues-presents as a deep crater with or without undermining adjacent tissue	0
		d. Stage 4. A full thickness of skin and subcutaneous tissues is lost, exposing muscle or bone	0
2.	TYPE OF ULCER	(For each type of ulcer, code for the highest stage in the last 7 days using scale in item M1-i.e., 0=none; stages 1,2,3,4)	
		a. Pressure ulcer-any lesion caused by pressure resulting in damage of underlying tissue	0
		b. Stasis ulcer-open lesion caused by poor circulation in the lower extremities	0
3.	HISTORY OF RESOLVED ULCERS	Resident had a ulcer that was resolved or cured in LAST 90 DAYS 0. No 1. Yes	0
4.	OTHER SKIN PROBLEMS OR LESIONS PRESENT	(Check all that apply during last 7 days)	
		a. Abrasions, bruises	a
		b. Burns (second or third degree)	b.
		c. Open lesions other than ulcers, rashes, cuts (e.g., cancer lesions)	c.
		d. Rashes e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster	d.
		e. Skin desensitized to pain or pressure	e.
		f. Skin tears or cuts (other than surgery)	f.
		g. Surgical wounds	g.
		h. NONE OF ABOVE	h. ✓
5.	SKIN TREATMENTS	(Check all that apply during last 7 days)	
		a. Pressure relieving device(s) for chair	a
		b. Pressure relieving device(s) for bed	b.
		c. Turning/repositioning program	c.
		d. Nutrition or hydration intervention to manage skin problems	d.
		e. Ulcer care	e.
		f. Surgical wound care	f.
		g. Application of dressing (with or without topical medications) other than to feet	g.
		h. Application of ointments/medications (other than to feet)	h.
		i. Other preventative or protective skin care (other than to feet)	i.
		j. NONE OF ABOVE	j. ✓
6.	FOOT PROBLEMS AND CARE	(Check all that apply during last 7 days)	
		a. Resident has one or more foot problems-e.g., corns, calluses, bunions, hammer toes, overlapping toes, pain, structural problems	a.
		b. Infection of the foot-e.g., cellulitis, purulent drainage	b.
		c. Open lesions on the foot	c.
		d. Nails/calluses trimmed during last 90 days	d.
		e. Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators)	e.
		f. Application of dressings (with or without topical medications)	f.
		g. NONE OF ABOVE	g. ✓

SECTION N. ACTIVITY PURSUIT PATTERNS

1.	TIME AWAKE	(Check appropriate time periods over last 7 days) Resident awake all or most of the time (i.e., naps no more than one hour per time period) in the: a. Morning [a. ✓] b. Afternoon [b. ✓] c. Evening d. NONE OF ABOVE	c. ✓ d.
(If resident is comatose, skip to SECTION O)			
2.	AVERAGE TIME INVOLVED IN ACTIVITIES	(When awake and not receiving treatments or ADL care) 0. Most-more than 2/3 of time 1. Some-from 1/3 to 2/3 of time 2. Little-less than 1/3 of time 3. None	1
3.	PREFERRED ACTIVITY SETTINGS	(Check all settings in which activities are preferred) a. Own room [a. ✓] b. Day/activity room [b. ✓] c. Inside NH/off unit [c.] d. Outside facility e. NONE OF ABOVE	d. e.

4.	GENERAL ACTIVITIES PREFERENCES (adapted to resident's current abilities)	(Check all PREFERENCES whether or not activity is currently available to resident)	
		a. Cards/other games [a.]	g. Trips/shopping g.
		b. Crafts/arts [b. ✓]	h. Walking/wheeling outdoors h.
		c. Exercise/sports [c. ✓]	i. Watching TV i. ✓
		d. Music [d. ✓]	j. Gardening or plants j.
		e. Reading/writing [e.]	k. Talking or conversing k. ✓
		f. Spiritual/religious activities [f. ✓]	l. Helping others l.
			m. NONE OF ABOVE m.
5.	PREFERS CHANGE IN DAILY ROUTINE	Code for resident preferences in daily routines 0. No change 1. Slight change 2. Major change	
		a. Type of activities in which resident is currently involved	0
		b. Extent of resident involvement in activities	0

SECTION O. MEDICATIONS

1.	NUMBER OF MEDICATIONS	(Record the number of different medications used in the last 7 days; enter "0" if none used)	05
2.	NEW MEDICATIONS	(Resident currently receiving medications that were initiated in the last 90 days) 0. No 1. Yes	1
3.	INJECTIONS	(Record the number of DAYS injections of any type received during the last 7 days; enter "0" if none used)	0
4.	DAYS RECEIVED THE FOLLOWING MEDICATION	(Record the number of DAYS during the last 7 days; enter "0" if not used. NOTE-enter "1" for long-acting meds used less than weekly)	
		a. Antipsychotic	a. 7
		b. Antianxiety	b. 0
		c. Antidepressant	c. 0
		d. Hypnotic	d. 0
		e. Diuretic	e. 0

SECTION P. SPECIAL TREATMENTS AND PROCEDURES

1.	SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS	a. SPECIAL CARE-Check treatments or programs received during the last 14 days	
		TREATMENTS	
		a. Chemotherapy	a.
		b. Dialysis	b.
		c. IV medication	c.
		d. Intake/output	d.
		e. Monitoring acute medical condition	e. ✓
		f. Ostomy care	f.
		g. Oxygen therapy	g.
		h. Radiation	h.
		i. Suctioning	i.
		j. Tracheostomy care	j.
		k. Transfusions	k.
		l. Ventilator or respirator	l.
		PROGRAMS	
		m. Alcohol/drug treatment program	m.
		n. Alzheimer's/dementia special care unit	n.
		o. Hospice care	o.
		p. Pediatric unit	p.
		q. Respite care	q.
		r. Training in skills required to return to the community (e.g., taking medications, house work, shopping, transportation, ADLs)	r.
		s. NONE OF ABOVE	s.

B. THERAPIES-Record the number of days and total minutes each of the following therapies was administered (for at least 15 minutes a day) in the last 7 calendar days (Enter "0" if none or less than 15 min. daily) [Note-count only post admission therapies]
(A) = # of days administered 15 minutes or more
(B)= total # of minutes provided in last 7 days

	DAYS (A)	MIN (B)
a. Speech - language pathology and audiology services	4	0235
b. Occupational therapy	5	0240
c. Physical therapy	0	0000
d. Respiratory therapy	0	0000
e. Psychological therapy (by any licensed mental health professional)	0	0000

2.	INTERVENTION PROGRAMS FOR MOOD, BEHAVIOR, COGNITIVE LOSS	(Check all interventions or strategies used in last 7 days-no matter where received)	
		a. Special behavior symptom evaluation program	a.
		b. Evaluation by a licensed mental health specialist in last 90 days	b. ✓
		c. Group therapy	c.
		d. Resident-specific deliberate changes in the environment to address mood/behavior patterns-e.g., providing bureau in which to rummage	d.
		e. Reorientation-e.g., cueing	e. ✓
		f. NONE OF ABOVE	f.

MDS 2 - Quarterly Form

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

SECTION AA. IDENTIFICATION INFORMATION

1.	RESIDENT NAME	RUNGE, HELEN	
2.	GENDER	1. Male 2. Female	2
3.	BIRTHDATE	08/03/1915	
4.	RACE/ ETHNICITY	1. American Indian/Alaskan Native 2. Asian/Pacific Islander 3. Black, not of Hispanic Origin 4. Hispanic 5. White, not of Hispanic origin	5
5.	SOCIAL SECURITY AND MEDICARE NUMBERS [C in 1st box if non med. no.]	a. Social Security Number 023-05-1066 b. Medicare number (or comparable railroad insurance number) 023051066A	
6.	FACILITY PROVIDER NO.	a. State No. 0927554 b. Federal No. 225356	
7.	MEDICAID NO. ["+" if pending, "N" if not a Medicaid recipient]	N	
8.	REASONS FOR ASSESSMENT	a. Primary reason for assessment 1. Admission Assessment (required by day 14) 2. Annual Assessment 3. Significant change in status assessment 4. Significant correction of prior assessment 5. Quarterly review assessment 10. Significant correction of prior quarterly assessment 0. NONE OF ABOVE b. Codes for assessments required for Medicare PPS or the State 1. Medicare 5 day assessment 2. Medicare 30 day assessment 3. Medicare 60 day assessment 4. Medicare 90 day assessment 5. Medicare readmission/return assessment 6. Other state required assessment 7. Medicare 14 day assessment 8. Other Medicare required assessment	05

9.	Signatures of Persons who Completed a Portion of the Accompanying Assessment or Tracking Form	

I certify that the accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

Signature and Title	Sections	Date
a. [signature]	except 4a AN	4-28-03
b. [signature] ADPC	N	4-28-03
c. [signature]	E	4/25/03
d.		
e.		
f.		
g.		
h.		
i.		
j.		
k.		
l.		

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SECTION A. IDENTIFICATION AND BACKGROUND

1.	RESIDENT NAME	RUNGE, HELEN
2.	ROOM NUMBER	365-1
3.	ASSESSMENT REFERENCE DATE	a. Last day of MDS observation period 04/23/2003 b. Original (0) or corrected copy of form (enter number of correction)
4a.	DATE OF REENTRY	Date of reentry from most recent temporary discharge to a hospital in last 90 days (or since last assessment or admission if less than 90 days) / /
6.	MEDICAL RECORD NO.	3-0012-0

SECTION B. COGNITIVE PATTERNS

1.	COMATOSE	(Persistent vegetative state/no discernible consciousness.) 0. No 1. Yes (Skip to Section G)	0
2.	MEMORY	(Recall of what was learned or known) a. Short-term memory OK - seems/appears to recall after 5 minutes 0. Memory OK 1. Memory problem	1
		b. Long-term memory OK - seems/appears to recall long past. 0. Memory OK 1. Memory problem	0
4.	COGNITIVE SKILLS FOR DAILY DECISION-MAKING	(Made decisions regarding tasks of daily life) 0. INDEPENDENT-decisions consistent/reasonable 1. MODIFIED INDEPENDENCE-some difficulty in new situations only 2. MODERATELY IMPAIRED-decisions poor; cues/ supervision required 3. SEVERELY IMPAIRED-never/rarely made decisions	2
5.	INDICATORS OF DELERIUM-PERIODIC DISORDERED THINKING/ AWARENESS	(Code for behavior in the last 7 days.) [Note: Accurate assessment requires conversations with staff and family who have direct knowledge of resident's behavior over this time.] 0. Behavior not present 1. Behavior present, not of recent onset 2. Behavior present, over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening)	
		a. EASILY DISTRACTED-(e.g., difficulty paying attention; gets sidetracked)	a.0
		b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS-(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day)	b.1
		c. EPISODES OF DISORGANIZED SPEECH-(e.g. speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought)	c.0
		d. PERIODS OF RESTLESSNESS-(e.g., fidgeting or picking at skin, clothing, napkins, etc; frequent position changes; repetitive physical movement or calling out)	d.0
		e. PERIODS OF LETHARGY-(e.g., sluggishness; staring into space; difficult to arouse; little body movement)	e.0
		f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY-(e.g., sometime better, sometimes worse; behaviors sometimes present, sometimes not)	f.1

SECTION C. COMMUNICATION/HEARING PATTERNS

4.	MAKING SELF UNDERSTOOD	(Expressing information content - however able) 0. UNDERSTOOD 1. USUALLY UNDERSTOOD-difficulty finding words or finishing thoughts 2. SOMETIMES UNDERSTOOD-ability is limited to making concrete requests 3. RARELY/NEVER UNDERSTOOD	0
6.	ABILITY TO UNDERSTAND OTHERS	(Understanding verbal information content - however able) 0. UNDERSTANDS 1. USUALLY UNDERSTANDS-may miss some part/ intent of message 2. SOMETIMES UNDERSTANDS-responds adequately to simple, direct communication 3. RARELY/NEVER UNDERSTANDS	1

SECTION E. MOOD AND BEHAVIOR PATTERNS

1.	INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD	(Code for indicators observed in last 30 days, irrespective of the assumed cause) 0. Indicator not exhibited in last 30 days 1. Indicator of this type exhibited up to five days a week 2. Indicator of this type exhibited daily or almost daily (6, 7 days a week)	
		VERBAL EXPRESSIONS OF DISTRESS	
		a. Resident made negative statements-e.g., "Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die"	a. 0
		b. Repetitive questions-e.g., "Where do I go; What do I do?"	b. 0
		c. Repetitive verbalizations-e.g., calling out for help, ("God help me")	c. 0
		d. Persistent anger with self or others-e.g., easily annoyed, anger at placement in nursing home; anger at care received	d. 0
		e. Self deprecation-e.g., "I am nothing; I am of no use to anyone"	e. 0
		f. Expression of what appear to be unrealistic fears-e.g., fear of being abandoned, left alone, being with others	f. 0
		g. Recurrent statements that something terrible is about to happen-e.g. believes he or she is about to die, have a heart attack	g. 0
		h. Repetitive health complaints-e.g., persistently seeks medical attention, obsessive concern with body functions	h. 0
		i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues	i. 1
		SLEEP-CYCLE ISSUES	
		j. Unpleasant mood in morning	j. 0
		k. Insomnia/change in usual sleep pattern	k. 0
		SAD, APATHETIC, ANXIOUS APPEARANCE	
		l. Sad, pained, worried facial expressions-e.g., furrowed brows	l. 0
		m. Crying, tearfulness	m. 1
		n. Repetitive physical movements-e.g., pacing, hand wringing, restlessness, fidgeting, picking	n. 1
		LOSS OF INTEREST	
		o. Withdrawal from activities of interest-e.g., no interest in long standing activities or being with family/friends	o. 0
		p. Reduced social interaction	p. 0
2.	MOOD PERSISTENCE	One or more indicators of depressed, sad or anxious mood were not easily altered by attempts to "cheer up", console, or reassure the resident over last 7 days 0. No mood indicators 1. Indicators present, easily altered 2. Indicators present, not easily altered	1
4.	BEHAVIORAL SYMPTOMS	(A) Behavioral symptom frequency in last 7 days 0. Behavior not exhibited in last 7 days 1. Behavior of this type occurred 1 to 3 days in last 7 days 2. Behavior of this type occurred 4 to 6 days, but less than daily 3. Behavior of this type occurred daily (B) Behavioral symptom alterability in last 7 days 0. Behavior not present OR behavior was easily altered 1. Behavior was not easily altered	(A) (B)
		a. WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety)	0 0
		b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS(others were threatened, screamed at, cursed at)	1 0
		c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused)	0 0
		d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS (made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding rummaged through others' belongings)	0 0
		e. RESISTS CARE (resisted taking medications, injections, ADL assistance, or eating)	1 1

Resident: RUNGE, HELEN Numeric Identifier: 3-0012-0

SECTION G. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS

1.	(A) ADL SELF-PERFORMANCE (Code for resident's PERFORMANCE OVER ALL SHIFTS during last 7 days, Not including setup) 0. INDEPENDENT-No help or oversight-OR-Help/oversight provided only 1 or 2 times during last 7 days 1. SUPERVISION-Oversight, encouragement or cueing provided 3 or more times during last 7 days-OR-Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days 2. LIMITED ASSISTANCE-Resident highly involved in activity; received physical help in guided maneuvering of limbs, or other nonweight bearing assistance 3 or more times-OR-More help provided only 1 or 2 times during last 7 days. 3. EXTENSIVE ASSISTANCE-While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times: - Weight-bearing support - Full staff performance during part (but not all) of last 7 days 4. TOTAL DEPENDENCE-Full staff performance of activity during entire 7 days. 8. ACTIVITY DID NOT OCCUR during entire 7 days.		(A)
a.	BED MOBILITY	How resident moves to and from lying position, turns side to side, and positions body while in bed.	0
b.	TRANSFER	How resident moves between surfaces-to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)	0
c.	WALK IN ROOM	How resident walks between locations in his/her room	0
d.	WALK IN CORRIDOR	How resident walks in corridor on unit	0
e.	LOCOMOTION ON UNIT	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair	0
f.	LOCOMOTION OFF UNIT	How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair	0
g.	DRESSING	How resident puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis	2
h.	EATING	How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)	0
i.	TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes	0
j.	PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum. (EXCLUDE baths and showers)	2
2.	BATHING	How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower. (EXCLUDE washing of back and hair.) Code for most dependent in self-performance and support.) (A) BATHING SELF PERFORMANCE codes appear below 0. Independent-No help provided 1. Supervision-Oversight help only 2. Physical help limited to transfer only 3. Physical help in part of bathing activity 4. Total dependence 8. Activity itself did not occur during entire 7 days	(A)	2
4.	FUNCTIONAL LIMITATION IN RANGE OF MOTION (see training manual)	(Code for limitations during last 7 days that interfered with daily functions or placed resident at risk of injury) (A) RANGE OF MOTION: 0. No limitation; 1. Limitation on one side; 2. Limitation on both sides (B) VOLUNTARY MOVEMENT: 0. No loss; 1. Partial loss; 2. Full loss	(A)	(B)
		a. Neck	0	0
		b. Arm-Including shoulder or elbow	0	0
		c. Hand-Including wrist or fingers	0	0
		d. Leg-Including hip or knee	0	0
		e. Foot-Including ankle or toes	0	0
		f. Other limitation or loss	0	0
6.	MODES OF TRANSFER	(Check all that apply during last 7 days) a. Bedfast all or most of time b. Bed rails used for bed mobility or transfer f. NONE OF ABOVE		a. b. f. ✓

SECTION H. CONTINENCE IN LAST 14 DAYS

1.	CONTINENCE SELF-CONTROL CATEGORIES (Code for resident's PERFORMANCE OVER ALL SHIFTS) 0. CONTINENT - Complete control [includes use of indwelling urinary catheter or ostomy device that does not leak urine or stool] 1. USUALLY CONTINENT - BLADDER, incontinent episodes once a week or less; BOWEL, less that weekly 2. OCCASIONALLY INCONTINENT - BLADDER, 2 or more times a week but not daily; BOWEL, once a week 3. FREQUENTLY INCONTINENT - BLADDER, tended to be incontinent daily, but some control present (e.g., on day shift); BOWEL, 2-3 times per week 4. INCONTINENT - Had inadequate control. BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time		
a.	BOWEL CONTINENCE	Control of bowel movement, with appliance or bowel continence program, if employed	0
b.	BLADDER CONTINENCE	Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., foley) or continence programs, if employed	0
2.	BOWEL ELIMINATION PATTERN	d. Fecal impaction e. NONE OF ABOVE	d. e. ✓
3.	APPLIANCES AND PROGRAMS	a. Any scheduled toileting plan b. Bladder retraining program c. External(condom) catheter d. Indwelling catheter i. Ostomy present j. NONE OF ABOVE	a. b. c. d. i. j. ✓

SECTION I. DISEASE DIAGNOSES

2.	INFECTIONS	j. Urinary tract infection in last 30 days m. NONE OF ABOVE	j. m. ✓
3.	OTHER CURRENT DIAGNOSES AND ICD-9 CODES	(Include only those diseases diagnosed in the last 90 days that have a relationship to current ADL status, behavior status, medical treatments, nursing monitoring, or risk of death) a. OSTEOARTHROSIS-GEN 715.00 b. SENILE DEMENTIA WI 290.20	

SECTION J. HEALTH CONDITIONS

1.	PROBLEMS CONDITIONS	(Check all problems present in last 7 days) c. Dehydrated; output exceeds input i. Hallucinations p. NONE OF ABOVE	c. i. p. ✓
2.	PAIN SYMPTOMS	(Check the highest level of pain present in the last 7 days) a. FREQUENCY with which resident complains or shows evidence of pain 0. No pain (skip to J4) 1. Pain less than daily 2. Pain daily b. INTENSITY of pain 1. Mild pain 2. Moderate pain 3. Times when pain is horrible or excruciating	0
4.	ACCIDENTS	(Check all that apply) a. Fell in past 30 days b. Fell in past 31-180 days c. Hip fracture in last 180 days d. Other fractures in last 180 days e. NONE OF ABOVE	a. b. c. d. e. ✓
5.	STABILITY OF CONDITIONS	a. Conditions/diseases make resident's cognitive, ADL, mood or behavior patterns unstable-(fluctuating, precarious, or deteriorating) b. Resident experiencing an acute episode or a flare-up of a recurrent or chronic-problem c. End-stage disease, 6 or fewer months to live d. NONE OF ABOVE	a. ✓ b. c. d.

SECTION K. ORAL/NUTRITIONAL STATUS

3.	WEIGHT CHANGE	a. Weight loss-5% or more in last 30 days or 10% in last 180 days 0. No 1. Yes	0
		b. Weight gain-5% or more in last 30 days or 10% in last 180 days 0. No 1. Yes	0
5.	NUTRITIONAL APPROACHES	b. Feeding tube h. On a planned weight change program i. NONE OF ABOVE	b. h. i. ✓

Resident: RUNGE, HELEN Numeric Identifier: 3-0012-0

SECTION M. SKIN CONDITIONS

1.	ULCERS (Due to any cause)	(Record the number or ulcers at each ulcer stage-regardless of cause. If none present at a stage, record "0" (zero). Code all that apply during last 7 days. Code 9=9 or more.) [Requires full body exam.]	Number at stage
		a. Stage 1. A persistent area of skin redness, (without a break in the skin) that does not disappear when pressure is relieved	0
		b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion blister, or shallow crater	0
		c. Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues-presents as a deep crater with or without undermining adjacent tissue	0
		d. Stage 4. A full thickness of skin and subcutaneous tissues is lost, exposing muscle or bone	0
2.	TYPE OF ULCER	(For each type of ulcer, code for the highest stage in the last 7 days using scale in item M1-i.e., 0=none; stages 1,2,3,4)	
		a. Pressure ulcer-any lesion caused by pressure resulting in damage of underlying tissue	0
		b. Stasis ulcer-open lesion caused by poor circulation in the lower extremities	0

SECTION N. ACTIVITY PURSUIT PATTERNS

1.	TIME AWAKE	(Check appropriate time periods over last 7 days) Resident awake all or most of the time (i.e., naps no more than one hour per time period) in the:			
		a. Morning	a. ✓	c. Evening	c. ✓
		b. Afternoon	b. ✓	d. NONE OF ABOVE	d.
(If resident is comatose, skip to SECTION O)					
2.	AVERAGE TIME INVOLVED IN ACTIVITIES	(When awake and not receiving treatments or ADL care) 0. Most-more than 2/3 of time 1. Some-from 1/3 to 2/3 of time 2. Little-less than 1/3 of time 3. None			1

SECTION O. MEDICATIONS

1.	NUMBER OF MEDICATIONS	(Record the number of different medications used in the last 7 days; enter "0" if none used)	07
4.	DAYS RECEIVED THE FOLLOWING MEDICATION	(Record the number of DAYS during the last 7 days; enter "0" if not used. NOTE-enter "1" for long-acting meds used less than weekly)	
		a. Antipsychotic	a. 7
		b. Antianxiety	b. 7
		c. Antidepressant	c. 0
		d. Hypnotic	d. 0
		e. Diuretic	e. 0

SECTION P. SPECIAL TREATMENTS AND PROCEDURES

4.	DEVICES AND RESTRAINTS	Use the following codes or the last 7 days: 0. Not used 1. Used less than daily 2. Used daily	
		Bed rails	
		a. -Full bed rails on all open sides of bed	a. 0
		b. -Other types of side rails used (e.g., half rail, on one side)	b. 2
		c. Trunk restraint	c. 0
		d. Limb restraint	d. 0
		e. Chair prevents rising	e. 0

SECTION Q. DISCHARGE POTENTIAL AND OVERALL STATUS

2.	OVERALL CHANGE IN CARE NEEDS	Resident's overall self sufficiency has changed significantly as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No Change 1. Improved-receives fewer supports, needs less restrictive level of care 2. Deteriorated-receives more support	0

SECTION R. ASSESSMENT INFORMATION

2. SIGNATURE OF PERSON COORDINATING THE ASSESSMENT:

S Edwardson

a. Signature of RN Assessment Coordinator (sign on above line)

b. Date RN Assessment Coordinator signed as complete 04-08-2003

MDS 2.0 September, 2000

0 0 3 9 5